

The United Nations logo, featuring a world map with latitude and longitude lines, surrounded by a laurel wreath, is centered in the background.

# **Meeting of development partners on nutrition**

13 May 2009



# Agenda

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**Welcome and introductions**

**Overview of current National Nutrition Strategy (NNS) / National Plan of Action for Nutrition (NPAN) process**

**Initial discussion of priorities for action**

- Review of current situation and activities

**Discuss options for working structure, communication and coordination between development partners**

**Next steps and closing**



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# The process for NNS/NPAN development

**National Nutrition Policy (NNP) endorsed by Prime Minister in December 2008, dissemination is currently underway**

- Central workshop 8-11 April, Northern in 6-9 May
- Southern workshop planned for 26-29 May

**National Nutrition Strategy (NNS) and Plan of Action (NPAN) under development**

- Completion targeted for End of July 2009
- National Plan of Action for Nutrition will lay out Government implementation plan through 2015

**High-level commitment from Government to put nutrition centrally in 7<sup>th</sup> Plan**

- Timeline for NNS/NPAN aligned to input into 7<sup>th</sup> Plan

**UN agencies are working closely with lead technical ministries to complete NNS and NPAN**

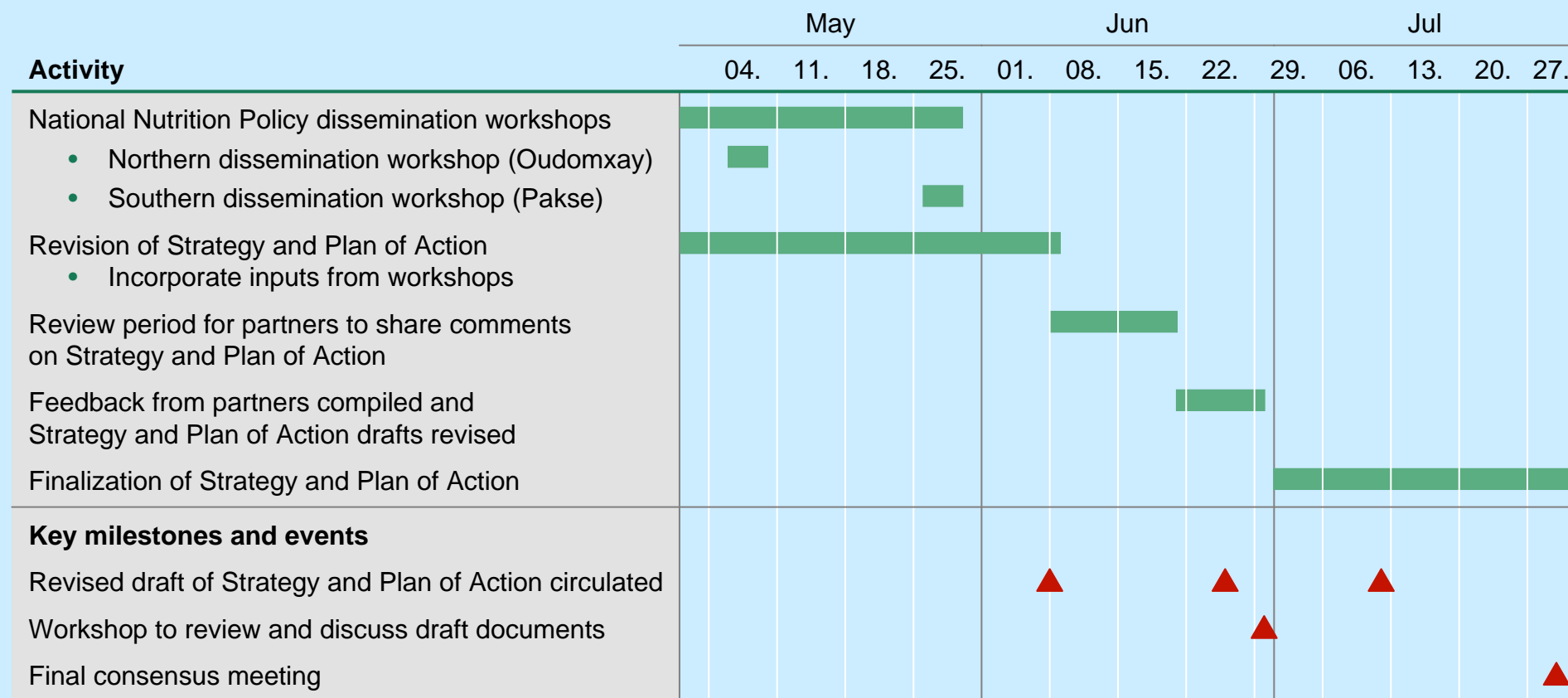
- Working Group chaired by FAO, includes UNICEF, WFP, WHO, World Bank, ADB, and INGO representatives



## Next steps

- **Revision of draft NNS and NPAN ongoing**
- **Southern WS 26-29 May**
  - Receive inputs from Provincial stakeholders to the NNS/NPAN
- **Early June**
  - All inputs compiled and the updated documents will be sent to DPs for their further inputs
- **Mid/end of June**
  - Next updated version
  - A meeting with GoL and DPs to be arranged to discuss the documents
- **Final consensus meeting end of July**

# Timeline for finalization of National Nutrition Strategy (NNS) and Plan of Action (NPAN)





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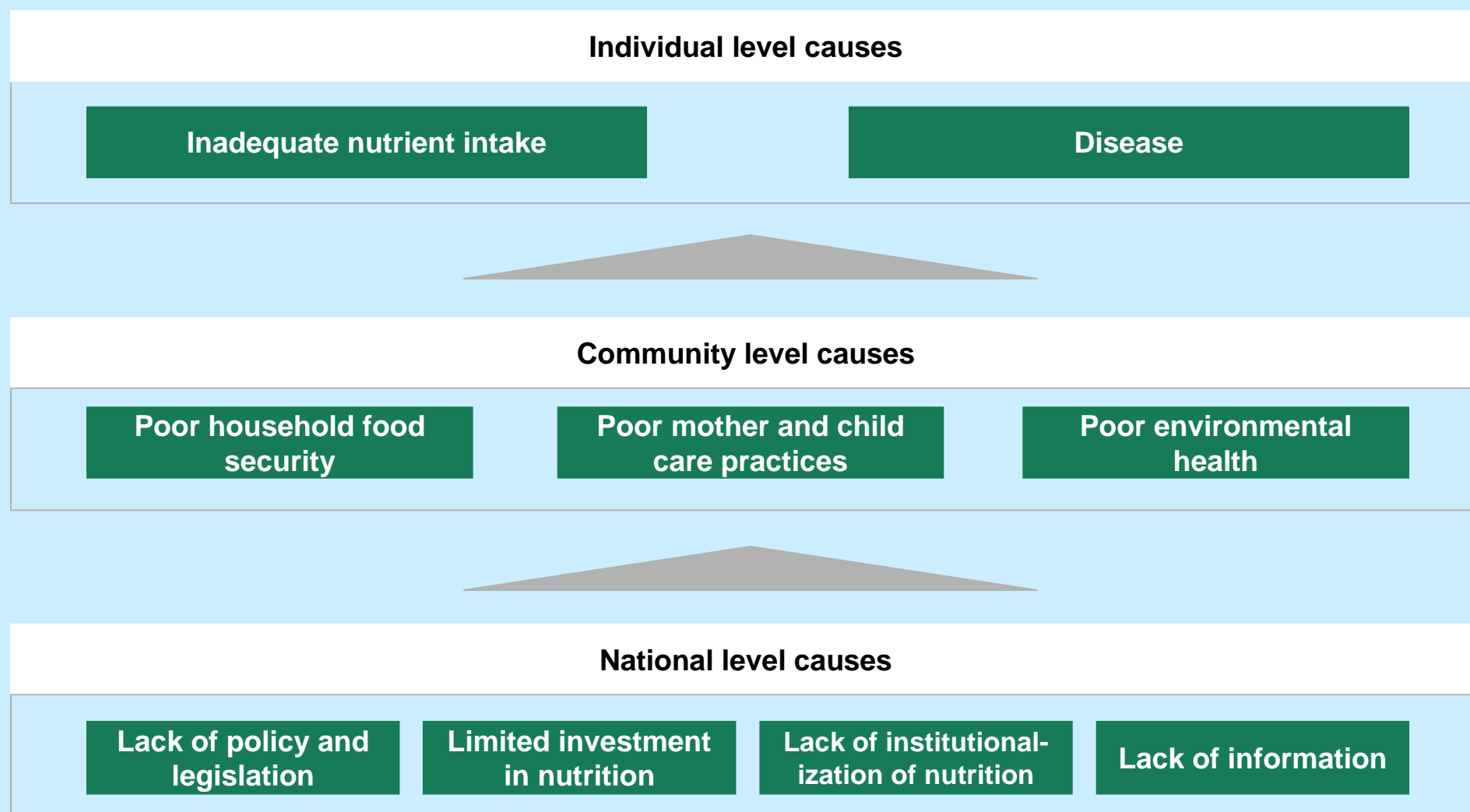
**Initial discussion of priorities for action**

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# Malnutrition has multiple underlying causes relating to behaviour and education, food security, health services





# National Nutrition Policy lays out objectives to address immediate and root causes of malnutrition



## Targeting causes at individual level

1

Improve nutrient intake

2

Prevent and reduce food and vector borne diseases

## Targeting causes at community level

3

Improve food access and availability

4

Improve mother and child care and education

5

Improve environmental health

## Targeting causes at national level

6

Improve nutrition programming, management, & M&E

7

Make priority investment in nutrition

8

Strengthen nutrition capacity within GoL

9

Facilitate action-oriented research & info. systems

10

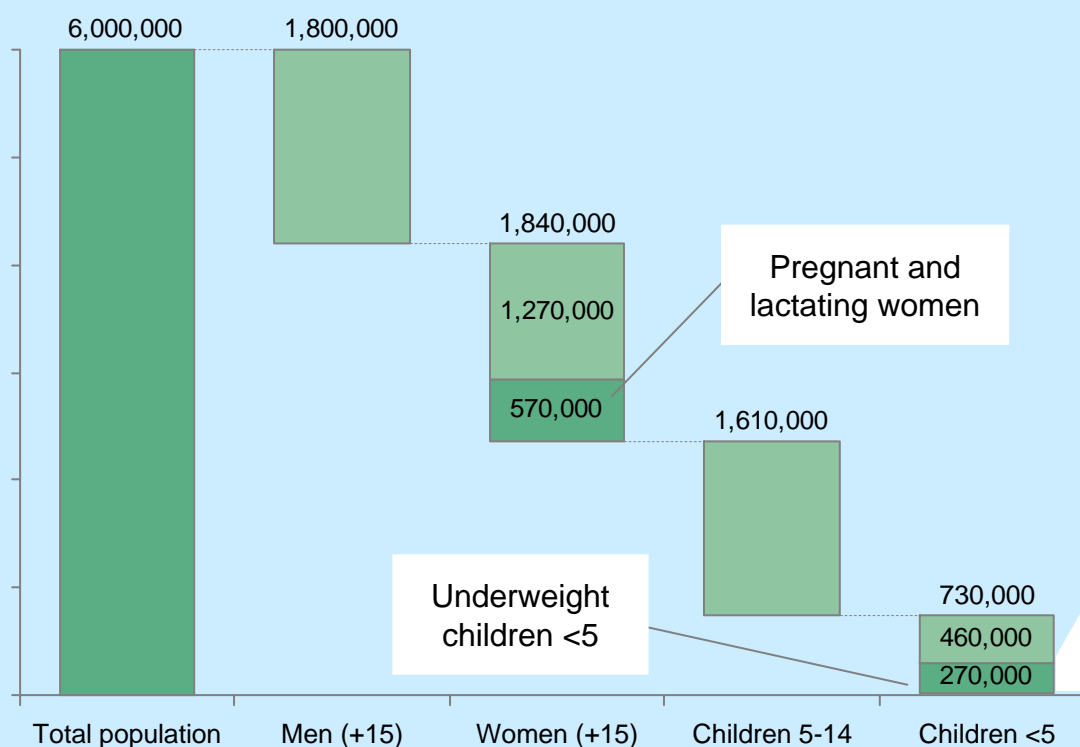
Make nutrition central in socio-economic development



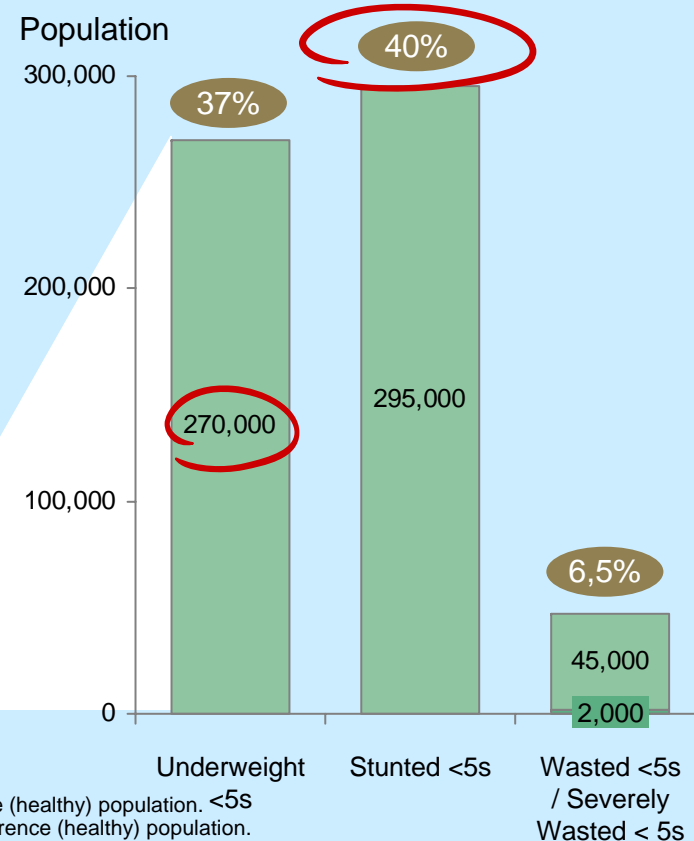
# ~270,000 underweight children <5 in Lao PDR

Stunting rate especially very high

## Demographic split-up of Lao PDR



## Undernutrition among children <5



1. Stunting: Low height for age or height for age more than a standard deviation of 2 below the median value of the reference (healthy) population. <5s

2. Underweight: Low weight for age or weight for age more than a standard deviation of 2 below the median value of the reference (healthy) population.

3. Wasting: Low weight for height or weight for height more than a standard deviation of 2 below the median value of the reference (healthy) population.

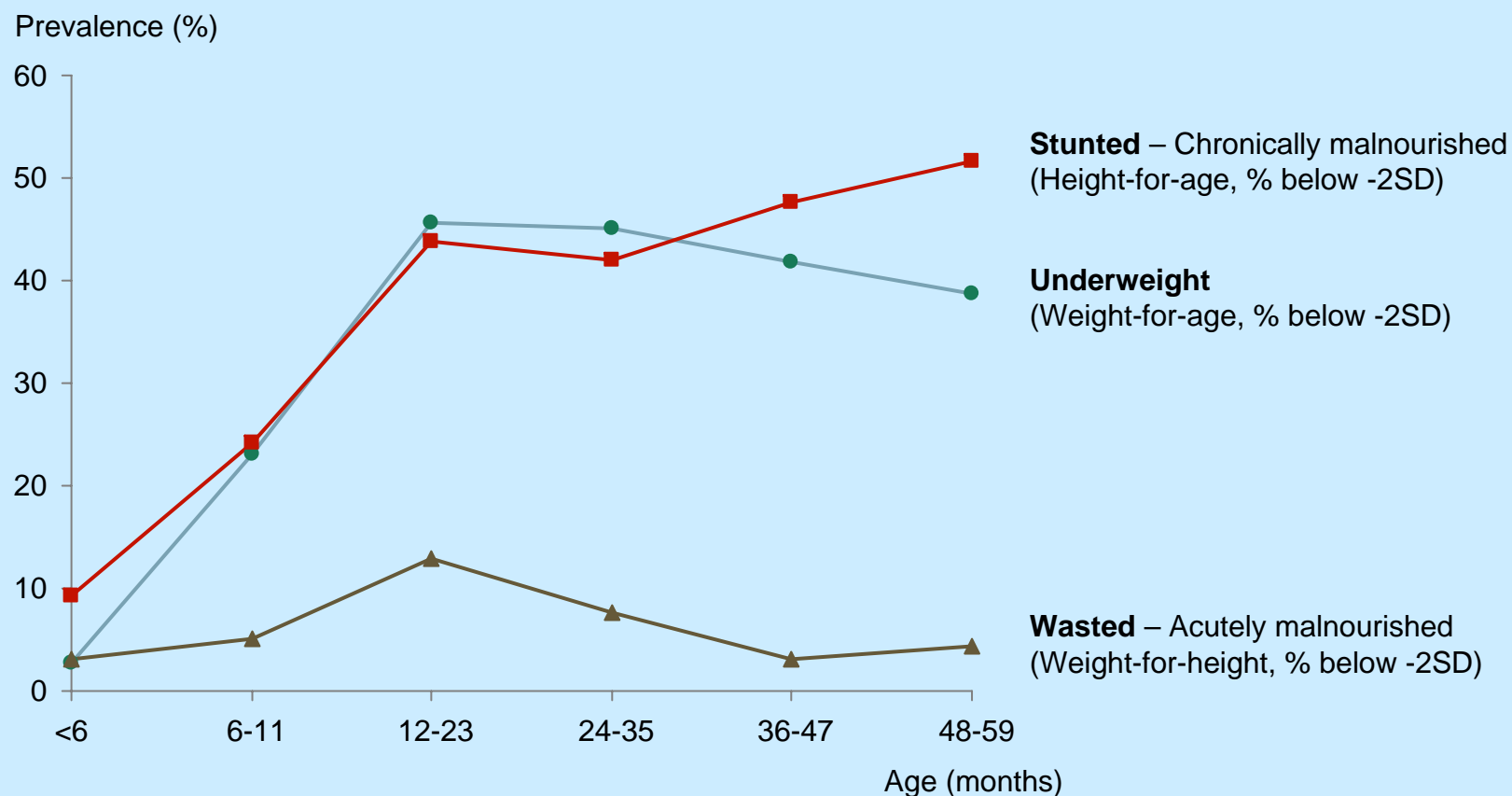
Source: Total population (2008), % Men+15, Women +15, Children 5-15: extrapolated from 2005 Population Census; Children < 5, Underweight, Stunting and Wasting : MICS3 2006

● % of children under 5

# Sharp increase in stunting and underweight between 6 and 24 months



## Percentage of children 0-59 months who are under-nourished



Source: MICS III – NNS, 2006. NCHS standards used.

Note: CFSVA shows similar trends, with stunting and underweight increasing most dramatically between 6-24 months: stunting increases from 23% to 51%, underweight from 20% to 32%. CFSVA uses WHO standards.



# Key factors contributing to malnutrition in Lao PDR

## Individual causes

### Inadequate nutrient intake

#### **Sufficient caloric intake through rice/staples, but diversity of foods is insufficient**

- Diets are highly staple-focused; very low consumption of fats and fruits
- Low protein intake among food insecure households
- Anemia a severe public health problem among children <2, women of reproductive age

### Disease

#### **Disease contributes to poor nutritional status of children**

- Parasitic infection is extremely high: 54%, as high as 90% in Khmou language group
- Highest diarrhea prevalence among children < 2 years
- Malaria rates have decreased, but high concentration in South (over 90% cases in 6 provinces)

## Community causes

### Poor mother and child care practices

#### **Lack of nutrition knowledge leads to poor quality and diversity of food consumption**

#### **Current infant and child feeding practices key driver of malnutrition among children <5**

- Late initiation of breastfeeding, low exclusive breastfeeding for children <6 months
- Mothers don't have knowledge of appropriate complementary feeding practices

#### **Widespread practice of food taboos affects mother's health and quality of breastmilk**

### Poor environmental health

#### **Low utilization and quality issues of health services – particularly for MCH services (antenatal care, delivery in health facility) contribute to poor nutrition in infants**

#### **Limited access to clean water and sanitation**

- Water contamination during household use, unsafe storage issues largely unaddressed

### Poor household food security

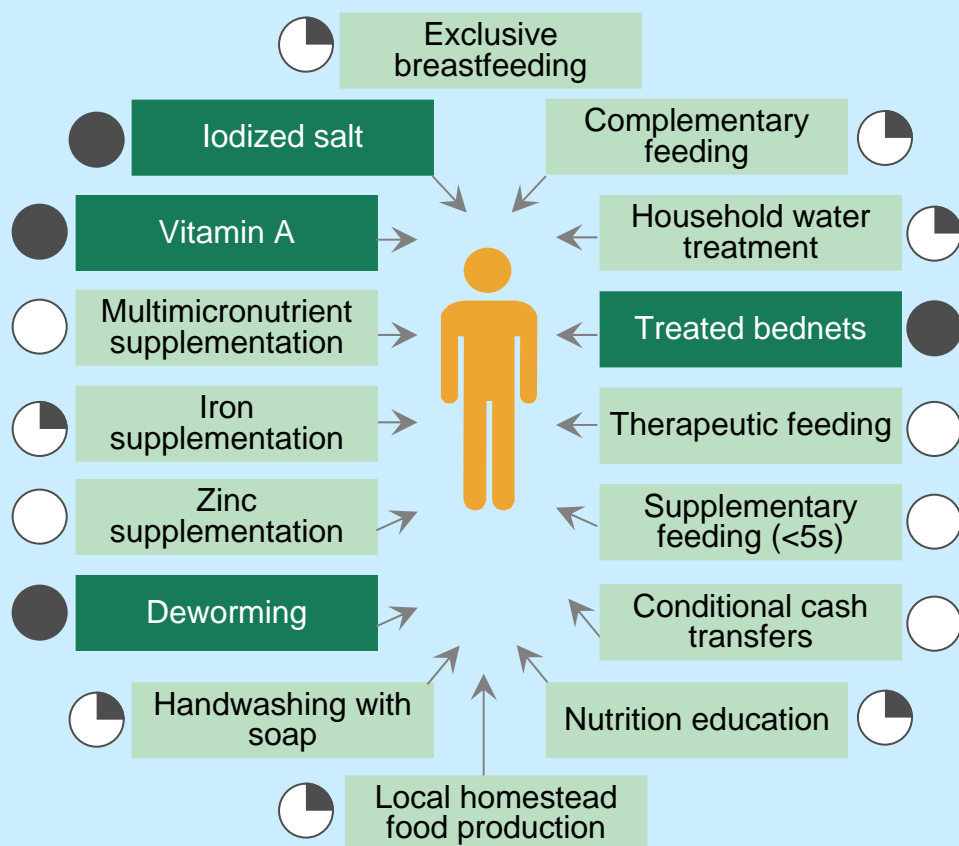
#### **Food poverty may be declining but 2/3 of rural population vulnerable to food insecurity**

- Most vulnerable are asset poor, those practicing upland farming
- High proportion of lower income and larger (8 or more members) households are food deprived
- Wild food sources are critical for all food consumption groups

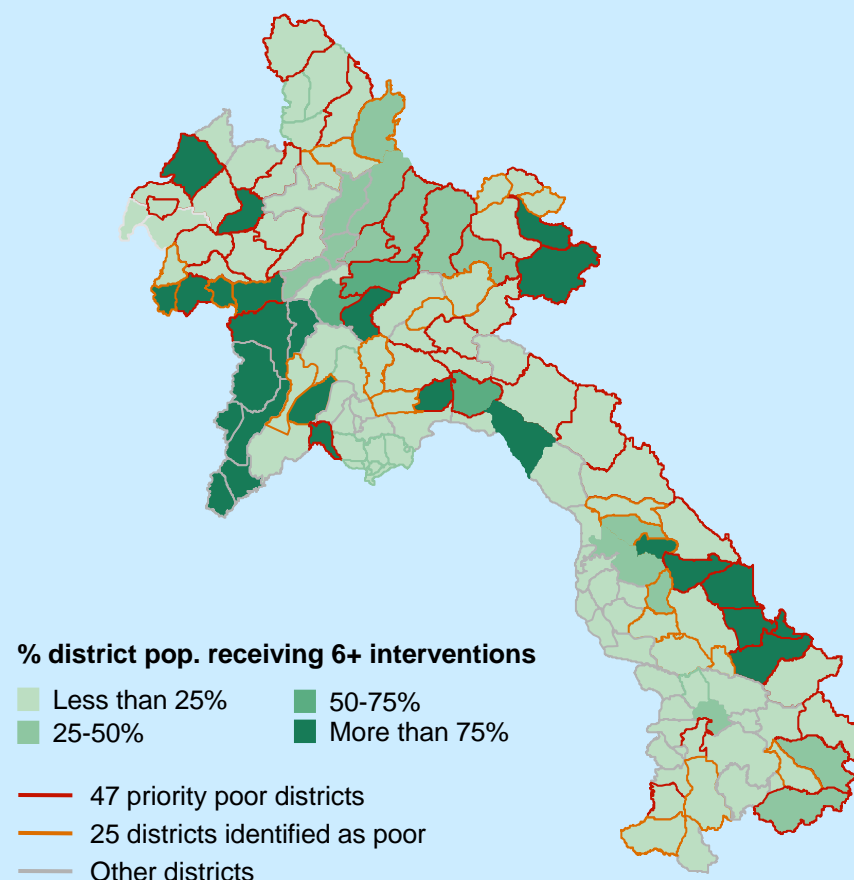
# Few children receive package of nutrition interventions

Central region, Mekong basin have especially low coverage

A typical child in Lao PDR receives only ~4 of the interventions it needs



















~70% of districts cover less than 25% of population with package of 6+ interventions



Note: Map produced by the NSC, July 2003.

Source: Poverty statistics reports, provincial committees/authorities; data provided by Government and development partners; REACH analysis.

# Multiple delivery channels used, but those with highest coverage not used to full potential

	Channel	Channel Size	Potential Channel Reach <sup>1</sup>	Current Interventions Delivered	Current Reach <sup>1</sup>
Main Delivery Channels	Community-based	13,000 VHVs; 5,000 TBAs; at least 1 LWU <sup>2</sup> representative per village	LWU present in every village in Lao PDR 100% 	Scattered activities, primarily supported by INGOs – BF, CF, HWT, HwS, ITNs, TF, HFP	20% 
	Hospitals	4 central, 13 provincial and 116 district hospitals; 739 health centers; 11,037 health officials	20% of deliveries with skilled personnel <sup>3</sup> 20% 	BF reaching 10% of women; Deworming and Vitamin A 19%; Iron folate 20.5% and ITNs < 10%; TF done for < 1% of SAM	<1-20% 
	Outreach	Visits to villages 2 to 4 times/year with trained health personnel; currently ~1531 villages served.	70% of EPI coverage through outreach/mobile clinics 70% 	BF, CF, Vitamin A, Deworming, HwS and NE conducted within MCH outreach package; HWT, ITN, HFP promotion only by some staff	9% 
Supporting Channels	Agricultural Extension	Extension officers in every district; 1 for every 5 to 10 villages <sup>5</sup>	Extension officers cover most of country ~100% 	Technical support for homestead food production; fish and livestock support; some community gardens as demonstrations	25% 
	Education System/Schools	8,830 schools in total, of which 4,242 are complete primary schools	84% net enrolment rate in primary schools <sup>6</sup> 84% 	Iron given to women of reproductive age in 4 villages; food distributed through schools to up to 114,088K households through take-home rations	1-11% 
	Mass Campaign	Campaigns via primary schools, hospitals and health centers, mobile clinics, outreach, health facilities	Vitamin A and deworming reached 95% 95% 	Vitamin A, deworming reaching 95% of children < 5; ITNs reach ~80% of at-risk population	80-95% 
	Mass Media	32 radio stations and 30 TV channels; 83 magazines and newspapers published frequently	Coverage of mass media is national ~100% 	Nationwide handwashing promotion through avian influenza campaign; nationwide BF promotion started in 2009	~100% 
	Private Sector	7 key-producers of iodized salt (LSPG)	Iodized salt is nationally available ~100% 	Iodine fortification implemented at national scale	84% <sup>7</sup> 

Source of data other than footnotes: REACH analysis. 1. Reach refers to % of target beneficiaries covered by the channel. 2. VHV: Village Health Volunteers, TBA: Traditional Birth Attendants, LWU: Lao Women's Union; 3. MICS 2006; 4. data unavailable to determine what % of country receives outreach visit. 5. according to [http://www.regional.org.au/au/apen/2006/refereed/1/3134\\_vanasook.htm](http://www.regional.org.au/au/apen/2006/refereed/1/3134_vanasook.htm) 6. Ministry of Education 2005; 7. MICS 2006.



# Current channel usage in Lao PDR analyzed by intervention

		Interventions																	
		Excl. breast-feeding	Complementary feeding	Handwashing with soap	HH water treatment	Nutrition education	Deworming	Vitamin A	Iron	Zinc	Iodine	Sprinkles	ITN	Therapeutic feeding	Supplementary feeding	Local Homestead Food Production	Conditional Cash Transfer		
Delivery channels	Hospitals and Health centers	E	E	P+E	E	E	P	P	P	P	E		P	P			2		
	Outreach	E	E	E	E	E	P	P	P				P						
	Education system/schools			E	P+E	E	P <sup>1</sup>		P		E				P <sup>1</sup>	E			
	Mass media	E		E															
	Mass Campaign	E					P	P					P						
	Community-based	E	E	P+E	P+E	E	P	P	P		E		P	P	P	P			
	Private sector										P								
	Agricultural extension															P+E			
National Coverage % of target population																			
			Activities at scale within channel															No activities in place	
			Activities partially in place in channel (>25% of channel)														E	Educational activity	
			Activities at low scale in channel (<25% of channel)														P	Physical activity	
1. Does not reach children < 5. 2. Pilot phase only, needs to be determined.																			

1. Does not reach children < 5; 2. Pilot planned – launch date to be determined.



# Going forward: how to prioritize action?

Potential criteria for prioritization

Criteria	Description
<b>Expected impact</b>	<ul style="list-style-type: none"><li>• Does intervention address key causes of malnutrition?</li><li>• Evidence-base supports effectiveness of this intervention?</li></ul>
<b>Feasibility of implementation</b>	<ul style="list-style-type: none"><li>• Does intervention build on existing activities and structures?</li><li>• Does appropriate delivery mechanism exist?</li><li>• Is there already country-specific know-how?</li><li>• Will significant investments in capacity need to be made before implementation can begin?</li></ul>
<b>Cost-effectiveness</b>	<ul style="list-style-type: none"><li>• Are the costs and required resource inputs in line with the expected benefit, and with costs of other interventions?</li><li>• Are there synergies in bundling with other interventions?</li></ul>
<b>Sustainability</b>	<ul style="list-style-type: none"><li>• Does strong government ownership exist for implementation?</li><li>• Is delivery mechanism sustainable?</li></ul>

**Are there other key criteria?**





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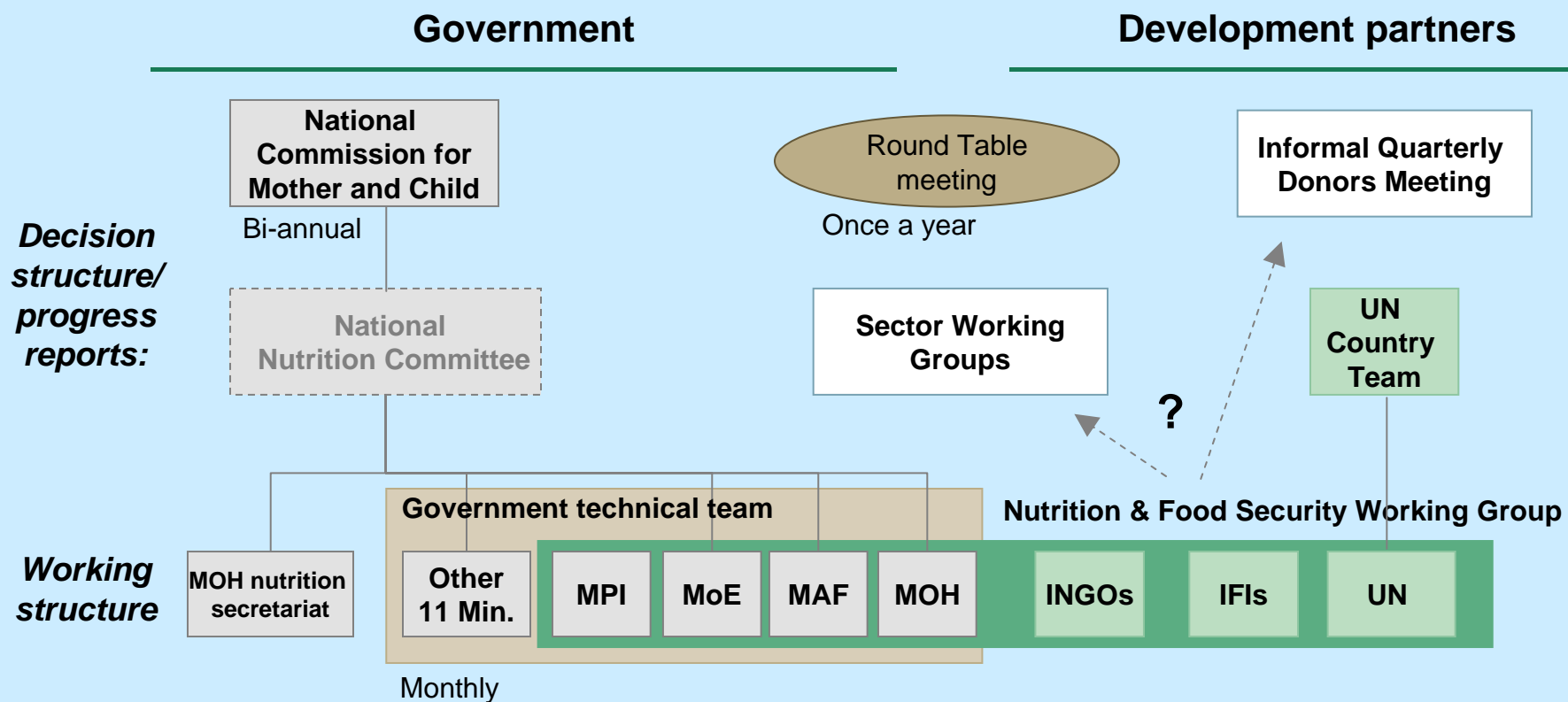
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# Need cooperation at every level to ensure an integrated approach



What is the right mechanism to inform/consult with other multilateral and bilateral stakeholders?

New body proposed in National Nutrition Policy